DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		49E076	B. WING			01/21/2015	
NAME OF PROVIDER OR SUPPLIER SNYDER NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 11 NORTH BROAD ST SALEM, VA 24153			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN O PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIEN		D BE COMPLETION	
F 000			F 00				
	conducted 01/20/15 the facility was in substant Part 483 Requirement	dicaid standard survey was hrough 01/21/15. The htial compliance with 42 CFR ts for Long Term Care afety Code survey/report will					
	at the time of the surv consisted of 10 curre	n #10) and 1 closed record					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: VA0229